



Commonwealth Coordinated Care Program Evaluation Update

Stakeholder Advisory Committee
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Overview

- **Review of CY 2014 – 2015 Care Coordination Observations**
- **Care Coordination Case Studies**
- **New Evaluation Document - *The Beneficiary Experience* (September 2015)**
- **Next Steps**
- **Questions, Comments, or Concerns**

Care Coordination Observations

- In evaluation, observations are essential because they happen in the “field” where services are delivered, allowing evaluators to learn more about program activities and processes
- Purpose of CCC observations is to observe delivery of services in real time to develop a more holistic understanding of the program
- Data collection consists of note taking, while observing care coordinators interacting with enrollees, families, and providers supplemented with interviews and document reviews

Observation Overview

- Since June 2014, the evaluation team has conducted 33 observations (79.2 hours) representing 73 encounters around the Central, Charlottesville, Roanoke, and Tidewater demonstration regions
- Data collection guided by certain questions:
 - What type of activity is occurring?
 - How does the enrollee receive needed assistance?
 - Is care for the enrollee being coordinated and if so, how and how well?

Observation Summary (*Tentative*)

- **Activities:**

- HRAs, ICTs, follow-ups, medical rounds, care planning, and MMP/enrollee meetings

- **Assistance:**

- Assessing needs, advocating, coaching, communicating, educating, building relationships, providing supplies, and connecting to social and health care supports

- **Care Coordination:**

- Building relationships, communicating, collaborating, resourcing, and delivering services

Case Study #1 – ICT Meeting

An MMP care coordinator (CC) and social worker conducted ICT on an enrollee with serious mental illness/liver mass at request of CSB due to concerns about losing residence at assisted living facility. ICT at local adult day support facility, and MMP, Magellan, support facility staff and enrollee participated. During meeting, staff assessed enrollee's cognitive abilities and enrollee asked MMP/Magellan staff to continue visiting her. MMP/Magellan staff indicated that enrollee had improved some since last meeting and concluded that residing in assisted living facility was beneficial. They agreed to work with support network to help enrollee adjust to facility and to schedule CT scan to examine her liver.



Case Study #2 – Clinical Assessment

During a clinical assessment of an enrollee with several chronic conditions, medical staff determined that she had undiagnosed chronic kidney disease (stage 3) and lower extremity problems due to poor circulation. Staff reviewed medications, performed cardiac evaluation, and referred enrollee to podiatry and exercise staff for further care. Staff communicated findings to enrollee's primary care physician (PCP) and MMP CC and scheduled quarterly visits with enrollee to begin CKD and lower circulatory treatment. Staff will continue to share treatment results with PCP and CC.

Case Study #3 – Initial Assessment

A CC conducted assessment of two newly assigned elderly enrollees (husband/wife) with various chronic conditions. During the encounter, CC determined they had limited English language abilities and were hungry (husband motioned to mouth saying “please”). After conversing with nursing facility (NF) staff, CC determined that NF lacked appropriate translation services. CC offered to arrange services and asked NF staff to convene care plan meeting with husband as soon as possible to discuss needs. NF staff expressed strong desire to collaborate to ensure delivery of suitable care to enrollees.

Case Study #4 – ICT Meeting

A CC conducted ICT with enrollee, service facilitator (SF), and family member. Prior to ICT, CC contacted PCP for follow up issues. CC reviewed care plan, medications (reduced from 15 to 8), and PERS with enrollee/family member. CC also offered to contact DME provider for replacement walker and to work with SF to resolve attendant pay issue. After ICT, CC reported that enrollee appeared to exhibit symptoms of an undiagnosed chronic disease, which she planned to share with PCP. During separate interview, SF reported that CC is good about following up with enrollees and communicating with providers (she goes “above and beyond the duties of her job”).)

The Beneficiary Experience (Sept. 2015)

- Short document (1 -3 pages) that portrays CCC Program from perspective of a specific enrollee, care coordinator, and/or other LTSS/BH provider(s) (may include one or more photographs)
- First *Beneficiary Experience* focuses on a Humana LTSS enrollee, care coordinator, and home health nurse
 - Beneficiary enrolled in CCC since April 2014
 - Receiving services through Humana's AAA pilot



CCC Enrollee Describing Relationship with Care Coordinator

...[she] really stays in touch with me to see if I need anything and when I do...she goes out of her way to do it...I don't even think of her as a coordinator, I just think of her as a friend...without her, who would I have to help me...hmm...nobody...I wouldn't have anybody except for the home care agency...I think that's a good idea, having a coordinator...I needed a Rollator...she went out of her way to make sure [I got it]...she tells me about things...like Silver Sneakers...she helps me when I do my [pharmacy] orders...she answers my questions...when I had to find a dermatologist, she quickly mailed me the list of people in the network...she stays on top of things, I don't know what else to say...

Next Steps

- Continue interviewing BH/LTSS enrollees and providers and observing MMP care coordination activities across demonstration regions in both institutional and community settings
- Partnering with Hampton/Newport News CSB and Richmond Behavioral Health Authority and District 19 CSB to conduct focus groups with BH enrollees/family members in August/September
- George Mason submits findings from surveys of CCC enrollees/disenrollees by September 30th

Questions, Comments, or Concerns

- ***THANK YOU!***
- For additional information on the CCC Evaluation, please contact:
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 - Or visit the **CCC Evaluation website**
http://www.dmass.virginia.gov/Content_pgs/ccc-eval.aspx